HOUSE OF REPRESENTATIVES STAFF ANALYSIS

BILL #: CS/HB 221 Out-of-Network Health Insurance Coverage
SPONSOR(S): Insurance & Banking Subcommittee, Trujillo and others
TIED BILLS: **IDEN./SIM. BILLS:** CS/SB 1442

REFERENCE	ACTION	ANALYST	STAFF DIRECTOR or BUDGET/POLICY CHIEF
1) Insurance & Banking Subcommittee	12 Y, 0 N, As CS	Peterson	Luczynski
2) Appropriations Committee		White	Leznoff
3) Health & Human Services Committee			

SUMMARY ANALYSIS

A Preferred Provider Organization (PPO) is a health plan that contracts with providers to create a network of providers who participate for an alternative or reduced rate of payment. Generally, the member is responsible only for required cost-sharing amounts if covered services are obtained from network (participating, preferred, or network) providers. However, if a member chooses to obtain services from an out-of-network (nonparticipating) provider, the member can be billed for the difference between the provider's charges and the PPO's approved reimbursement. In an Exclusive Provider Organization (EPO) arrangement, an insurance company contracts with hospitals, physicians, and other medical facilities. Insured members must use the participating hospitals or providers to receive covered benefits, subject to limited exceptions. A Health Maintenance Organization (HMO) provides health care services pursuant to contractual arrangements with preferred providers who have agreed to supply services to members at pre-negotiated rates. Traditionally, an HMO member must use the HMO's network of health care providers in order for the HMO to make payment of benefits.

Current law requires an HMO to provide coverage for emergency services and care without prior authorization and without regard for whether the provider has a contract with the HMO. The HMO must reimburse a nonparticipating provider the lesser of the provider's charges; the usual and customary rate for provider charges in the community; or the rate agreed to between the provider and the HMO. The nonparticipating provider may not collect additional reimbursement from the subscriber. In other words, the provider cannot balance bill the patient. The law does not currently prohibit providers who are not part of a preferred or exclusive provider network from balance billing patients for emergency or nonemergency services.

The bill prohibits out-of-network providers from balance billing members of a PPO or EPO for emergency services or for nonemergency services when the nonemergency services are provided in a network hospital and the patient had no ability and opportunity to choose a network provider. The bill establishes standards for determining reimbursement to the providers; authorizes the providers to initiate arbitration to determine additional reimbursement; requires the Department of Financial Services to maintain a list of qualified arbitrators and collect decisions; and provides requirements for the arbitration process, including responsibility for attorney fees and additional costs.

Finally, the bill: requires all PPOs to publish a list of their network providers on their websites, and to update the list monthly; requires all PPOs to give subscribers notice regarding the potential for balance billing when using out-of-network providers; subjects certain facilities and licensed health care practitioners to disciplinary action for violations of the prohibition on balance billing; and requires hospitals to publish information on their websites regarding their contracts with plans and providers of hospital-based services.

The bill has an indeterminate insignificant fiscal impact on the state and local governments.

The bill is effective October 1, 2016.

FULL ANALYSIS

I. SUBSTANTIVE ANALYSIS

A. EFFECT OF PROPOSED CHANGES:

Current Situation

Managed Care Organizations

Types[1]

Preferred Provider Organization[2]
A PPO is a health plan that contracts with providers, such as hospitals and doctors, to create a network of providers who participate for an alternative or reduced rate of payment. A PPO is an insurance product. PPO plan members generally see specialists without prior referral or authorization from the insurer. Generally, the member is only responsible for the policy co-payment, deductible, or co-insurance amounts if covered services are obtained from network providers. However, if a member chooses to obtain services from an out-of-network provider, those out-of-pocket costs likely will be higher. An insurer that offers a PPO plan must make its current list of preferred providers available to its members.

Exclusive Provider Organization[3]
In an EPO arrangement, an insurance company contracts with hospitals, physicians, and other medical facilities. Insured members must use the participating hospitals or providers to receive covered benefits, subject to limited exceptions.

Health Maintenance Organization[4]
An HMO is an organization that provides a wide range of health care services, including emergency care, inpatient hospital care, physician care, ambulatory diagnostic treatment and preventive health care pursuant to contractual arrangements with preferred providers in a designated service area. The network is made up of providers who have agreed to supply services to members at pre-negotiated rates. Traditionally, an HMO member must use the HMO's network of health care providers in order for the HMO to make payment of benefits. The use of a health care provider outside the HMO's network generally results in the HMO limiting or denying the payment of benefits for out-of-network services rendered to the member.[5]

Regulation
The Office of Insurance Regulation (OIR) licenses and regulates insurers, health maintenance organizations, and other risk-bearing entities.[6] To operate in Florida, an HMO must obtain a certificate of authority from OIR.[7] The Agency for Health Care Administration (AHCA) regulates the quality of care provided by HMOs under part III of ch. 641, F.S. Before receiving a certificate of authority from OIR, an HMO must receive a Health Care Provider Certificate from AHCA pursuant to part III of ch. 641, F.S.[8] As part of the certification process used by AHCA, an HMO must provide information to demonstrate that the HMO has the ability to provide quality of care consistent with the prevailing standards of care.[9]

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[1] *See generally* FLORIDA DEPARTMENT OF FINANCIAL SERVICES, *Health Insurance and Health Maintenance Organizations, A Guide for Consumers, available at*: http://ahca.myflorida.com/MCHQ/Health_Facility_Regulation/Commercial_Managed_Care/chmo.shtml (last visited Jan. 16, 2016).
[2] *See generally* s. 627.6471, F.S.
[3] *See generally* s. 627.6472, F.S.
[4] *See generally* part I of chapter 641, F.S.
[5] Section 641.31(38), F.S., creates an exception to this general rule. It authorizes an HMO to offer a point-of-service benefit. The benefit, offered pursuant to a rider, enables a subscriber to select, at the time of service and without referral, a nonparticipating provider for a covered service. The HMO may require the subscriber to pay a reasonable co-payment for each visit for services provided by a nonparticipating provider.
[6] s. 20.121(3)(a)1., F.S.
[7] ss. 641.21(1) and. 641.49, F.S.
[8] ss. 641.21(1) and 641.48, F.S.
[9] s. 641.495, F.S.

The Florida Insurance Code requires health insurers and HMOs to provide an outline of coverage or other information describing the benefits, coverages, and limitations of a policy or contract. This may include an outline of coverage describing the principal exclusions and limitations of the policy.[10]

Balance Billing[11]

Balance billing describes the situation where a health care provider seeks to collect payment from a patient for the difference between the provider's billed charges for a covered service and the amount that the managed care organization paid on the claim. Before the rise of managed care, consumers with insurance typically expected some balance billing. Under traditional indemnity insurance, the insured paid the provider directly then sought reimbursement from the insurer. The insurer reimbursed, minus any cost sharing, up to the policy amount. If the reimbursement was below the billed charge, then the patient would not be fully reimbursed.

Today most people with private insurance are covered by a managed care organization (MCO). Members must utilize the services of network providers to minimize out-of-pocket expenses. Typically, contracts between network providers include a "hold harmless" provision that protects members from being balance billed by a network provider for covered services. In consenting to these provisions, participating providers generally agree not to seek reimbursement from a member beyond payment of applicable cost-sharing requirements, such as copayments, co-insurance, or deductibles.

A member may choose to seek care from a nonparticipating provider, for example from a specialist regarded as an expert in the field. A member may utilize out-of-network providers unknowingly while receiving care at a network hospital. While radiologists, anesthesiologists, pathologists, and increasingly emergency room physicians are hospital-based physicians, generally they are not hospital employees and may or may not contract with the same MCOs as the hospital. Likewise, a member may receive—and be billed for—services from a nonparticipating provider if the member's network physician consults with a nonparticipating specialist. This is generally referred to as "surprise billing." Finally, a member may receive out-of-network care from an out-of-network hospital as a result of an emergency transport.

An analysis conducted for the California HealthCare Foundation in 2006 of 1.2 million residents with employer-sponsored commercial (private) insurance found that almost 11 percent of those studied used out-of-network services at some point during the year. Most out-of-network utilization occurred as a result of a hospital admission, or an emergency department visit without admission. The average balance bill (across facilities, physicians, and other professional providers) was $1,289 in addition to the average patient cost-sharing amount of $433. The average balance bill for an inpatient admission averaged $6,812.[12]

According to a recent study conducted by the Kaiser Family Foundation and the New York Times, one in five (20 percent) of U.S. adults ages 18 – 64 *with insurance* report that they or someone in their household had problems paying a medical bill.[13] Of those, 75 percent say that the amount they had to pay for insurance copays, deductibles, or coinsurance was more than they could afford.[14] Another 32 percent say they received care from an out-of-network provider that their insurance did not cover. For many, the bills were a surprise. Sixty-nine percent indicated that they were unaware that the provider was not in their plan's network when they received the care.[15]

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[10] s. 627.642, F.S.
[11] *See generally* CALIFORNIA HEALTHCARE FOUNDATION, *Unexpected Charges: What States Are Doing About Balance Billing* (April 2009), *available at* http://www.chcf.org/publications/2009/04/unexpected-charges-what-states-are-doing-about-balance-billing (last visited Jan. 15, 2015).
[12] *Id.* at 4.
[13] Liz Hamel, Mira Norton, Karen Pollitz, Larry Levitt, Gary Claxton and Mollyann Brodie, *The Burden of Medical Debt: Results from the Kaiser Family Foundation/New York Times Medical Bills Survey*, Jan. 2016, at 1, *available at* http://kff.org/health-costs/report/the-burden-of-medical-debt-results-from-the-kaiser-family-foundationnew-york-times-medical-bills-survey/?utm_campaign=KFF%3A+2015+December+KFF+NY+Times+Medical+Debt&utm_source=hs_email&utm_medium=email&_hsenc=p2ANqtz-811G5oUaaAYr6uoeChnST13pyBbh3AXerbZqYy-sz9DT7TXvXwILDCoV9tYHvY36G5i73DlRghX6-J-AViQkuqXJhEnA&_hsmi=24816172.
[14] *Id.* at 11.
[15] *Id.* at 12.

Current Prohibitions on Balance Billing

Currently, balance billing is prohibited for services provided under Medicaid;[16] workers' compensation insurance;[17] by an exclusive provider who is part of an EPO; [18] or by a provider who is under contract with a prepaid limited service organization.[19] In addition, the law provides that an HMO is liable to pay, and may not balance bill, for covered services provided to a subscriber whether or not a contract exists between the provider and the HMO.[20] However, the statute further qualifies the prohibition by saying that an HMO is liable for services rendered if the provider obtains authorization from the HMO prior to providing services. Thus, a provider can balance bill if authorization is denied or if the provider does not seek prior authorization. [21,22]

Florida Insurance Consumer Advocate

On October 15, 2015, the Insurance Consumer Advocate held a forum to solicit testimony from stakeholders on the issue of balance billing. On November 18, 2015, the Consumer Advocate presented her recommendations for legislation to implement the findings of the forum to the House Subcommittee on Insurance & Banking:[23]

- Hold consumers harmless (prohibit balance billing") in emergency and "surprise billing" situations.
- Establish an alternative dispute resolution process to allow nonparticipating providers to challenge the amount of payment received from an insurer.
- Conduct a study of network adequacy requirements applicable to insurers.
- Require disclosure in all contracts for services involving network providers of the potential billing consequences of using out-of-network providers.
- Require insurers to update their provider directories on a timely basis.
- Require hospitals to make data available regarding hospital-based providers who are not in the network.

Effect of Changes Related to Balance Billing

The bill prohibits out-of-network providers from balance billing members of a PPO or EPO for emergency services or for nonemergency services when the nonemergency services are provided in a network hospital and the patient had no ability and opportunity to choose a network provider. The effect is to eliminate balance billing in the emergency and "surprise" billing scenarios. This would mean consumers who have PPO or EPO coverage would only be responsible for billing differences in circumstances where they knowingly opted to receive out-of-network care. Under the bill, the protections for members of HMOs would remain unchanged.

Current Situation

Access to Emergency Services and Care

[16] s. 409.907(3)(j), F.S.; Medicaid managed care plans and their providers are required to comply with the Provider General Handbook, which expressly prohibits balance billing. In addition, the Statewide Medicaid Managed Care Contract (CORE contract) establishes minimum requirements for contracts between plans and providers. The CORE contract requires those contracts to prohibit balance billing, except for any applicable cost sharing. (E-mail from Josh Spagnola, Legislative Affairs Director, Florida Agency for Health Care Administration, excerpting relevant provisions from the Handbook and the CORE contract (March 16, 2015) (on file with the House Insurance & Banking Subcommittee).

[17] s. 440.13(13)(a), F.S.

[18] s. 627.6472(4)(e), F.S.

[19] s. 636.035(3) - (4), F.S.

[20] ss. 641.315(1) and 641.3154(1), F.S.

[21] *But see Joseph L. Riley Anesthesia Associates v. Stein*, 27 So. 3d 140, 145 (Fla. 5th DCA 2010). The Fifth DCA has held that an authorization issued to a contract provider for services (surgery) in a hospital is deemed an authorization for a hospital-based provider of medically necessary services (anesthesia) that are provided under an exclusive contract without regard for the existence of a contract with the HMO. In other words, if the main service is authorized, related services provided under an exclusive contract are deemed authorized and balance billing is prohibited. *See also* Rule 69O-191.049, F.A.C. (prohibiting hospital-based physicians from balance billing an HMO subscriber who receives covered services in a network hospital.)

[22] *See also* FLORIDA MEDICAL ASSOCIATION, *Balance Billing*, http://www.flmedical.org/LRC_Balance_billing.aspx (last visited Jan. 17, 2016).

[23] INSURANCE CONSUMER ADVOCATE, *Recommendations for a Balanced Approach to Unexpected Medical Expenses, Florida House of Representatives Insurance and Banking Subcommittee* (Nov. 18, 2015) (on file with the Insurance & Banking Subcommittee).

Hospital Care

In 1986, Congress enacted the Emergency Medical Treatment and Active Labor Act (EMTALA) to ensure public access to emergency services regardless of ability to pay. EMTALA imposes specific obligations on hospitals participating in the Medicare program which offer emergency services. Any patient who comes to the emergency department must be provided with a medical screening examination to determine if the patient has an emergency medical condition. If an emergency condition exists, the hospital must provide treatment within its service capability to stabilize the patient. If a hospital is unable to stabilize a patient, or if the patient requests, the hospital must transfer the patient to another appropriate facility.[24] A hospital that violates EMTALA is subject to civil monetary penalty,[25] termination of its Medicare agreement,[26] or civil suit by a patient who suffers personal harm.[27] EMTALA does not provide for civil action against a hospital's physicians.

Florida law imposes a similar duty.[28] The law requires AHCA to maintain an inventory of the service capability of all licensed hospitals that provide emergency care in order to assist emergency medical services (EMS or ambulance) providers and the public in locating appropriate medical care. Hospitals must provide all listed services when requested, whether by a patient, an emergency medical services provider, or another hospital, regardless of the patient's ability to pay. If the hospital is at capacity or does not provide the requested emergency service, the hospital may transfer the patient to the nearest facility with appropriate available services. Each hospital must ensure the services listed can be provided at all times either directly or through another hospital. A hospital is expressly prohibited from basing treatment and care on a patient's insurance status, economic status, or ability to pay. A hospital that violates Florida's access to care statute is subject to administrative penalties; denial, revocation, or suspension of its license; or civil action by another hospital or physician suffering financial loss. In addition, hospital administrative or medical staff are subject to civil suit by a patient who suffers personal harm, and may be found guilty of a second degree misdemeanor for a knowing or intentional violation. Physicians who violate the act are also subject to disciplinary action against their license or civil action by another hospital or physician suffering financial loss.

Prehospital Care

The Emergency Medical Transportation Services Act[29] similarly regulates the services provided by emergency medical technicians, paramedics, and air and ground ambulances. The act establishes minimum standards for emergency medical services personnel, vehicles, services, and medical direction, and provides for monitoring of the quality of patient care. The standards are administered and enforced by the Department of Health (DOH). Ambulance services operate pursuant to a license issued by the DOH and a certificate of public convenience and necessity issued from each county in which the provider operates.[30] A licensee may not deny a person needed prehospital treatment or transport for an emergency medical condition.[31] A violation may result in denial, suspension, or revocation of a license; reprimand; or fine.[32]

In general, the medical director of an ambulance provider is responsible for issuing standing orders and protocols to the ambulance service provider to ensure that the patient is transported to a facility that offers a type and level of care appropriate to the patient's medical condition,[33] with separate protocols required for stroke patients.[34] Trauma alert patients are an exception to the general requirement and are required to be transported to an approved trauma center.[35]

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[24] Emergency Medical Treatment and Active Labor Act (EMTALA), 42 U.S.C. §1395dd.; *see also* CENTERS FOR MEDICARE & MEDICAID SERVICES, *Emergency Medical Treatment & Labor Act (EMTALA)*, http://www.cms.gov/Regulations-and-Guidance/Legislation/EMTALA/index.html?redirect=/emtala/ (last visited Jan. 16, 2016).
[25] 42 U.S.C. § 1395dd(d)(1).
[26] 42 C.F.R. § 489.24(f).
[27] 42 U.S.C. § 1395dd(d)(2).
[28] *See* s. 395.1041, F.S.
[29] Part III of chapter 401, F.S. (ss. 401.2101 – 401.465, F.S.).
[30] s. 401.25(2)(d), F.S.
[31] s. 401.45, F.S.
[32] s. 401.411, F.S.
[33] Rule 64J-1.004()(a), F.A.C.
[34] s. 395.3041(3), F.S.
[35] s. 395.4045, F.S.

State law establishes the provision of ambulance services as a core function of county government.[36] Counties may provide the service directly, under contract with one or more private or municipal providers, or both. In 2015, 61 counties and 97 municipalities were licensed to provide emergency medical services.[37] This represents more than half of all licensed providers.

Payment for Emergency Services and Care

Florida Law

A PPO must charge a member the same copayments for emergency care whether the care is provided by a participating or nonparticipating provider.[38]

An EPO plan must ensure that emergency care is available 24 hours a day and 7 days a week. Insurers issuing exclusive provider contracts must pay for services provided by non-exclusive providers if the services are for symptoms requiring emergency care and a network provider is not reasonably accessible.[39]

An HMO must provide coverage without prior authorization for prehospital transport or treatment or for emergency services and care[40] that is rendered by either a participating or nonparticipating provider.[41] An HMO must charge a subscriber the same copayments for emergency care whether the care is provided by a participating or nonparticipating provider. [42]

The law requires HMOs to pay nonparticipating providers specified minimum reimbursement for emergency services. Specifically, HMOs must reimburse providers the lesser of:[43]

- The provider's charges;
- The usual and customary provider charges for similar services provided in the community; or
- The charge mutually agreed to by the HMO and the provider.

Reimbursement is net of any applicable copayment.

Patient Protection and Affordable Care Act (PPACA)

PPACA was signed into law on March 23, 2010.[44] Among its sweeping changes to the U.S. health care system are requirements for health insurers to make coverage available to all individuals and employers, without exclusions for preexisting conditions and without basing premiums on any health-related factors. PPACA imposes many insurance requirements including required benefits, rating and underwriting standards, required review of rate increases, coverage for adult dependents, and other requirements.[45]

PPACA requires that coverage for emergency services must be provided without prior authorization and regardless of whether the provider is a network provider. Services provided by out-of-network providers must be provided with cost-sharing that is no greater than that which would apply for a network provider and without regard to any other restriction other than an exclusion or coordination of benefits, an affiliation or waiting period, and cost-sharing. In addition, plans must reimburse out-of-network providers the greater of:

- The median in-network rate;

[36] *See* s. 125.01(1)(e), F.S.; *see also* s. 155.22, F.S.
[37] Florida Department of Health, *EMS Provider Type Reports* (March 16, 2015) (on file with the House Insurance & Banking Subcommittee).
[38] s. 627.6405(4), F.S.
[39] s. 627.6472, F.S.
[40] "Emergency services and care" include the medical screening, examination, and evaluation to determine whether an emergency medical condition exists and the care, treatment, or surgery necessary to relieve or eliminate the emergency medical condition. s. 641.47(8), F.S.
[41] ss. 641.31(12) and 641.513(1)(a), F.S.
[42] s. 641.31097(4), F.S.
[43] s. 641.513(5), F.S.
[44] Patient Protection and Affordable Care Act, Pub. L. No. 111-148, H.R. 3590, 11th Cong. (March 23, 2010). On March 30, 2010, PPACA was amended by P.L. 111-152, the Health Care and Education Reconciliation Act of 2010.
[45] Most of the insurance regulatory provisions in PPACA amend Title XXVII of the Public Health Service Act. 42 U.S.C. 300gg et seq.

- The usual and customary reimbursement, calculated using the plan's formula; or
- The Medicare rate.[46]

Grandfathered health plans are exempt from these requirements.[47] PPACA does not prohibit balance billing. A guidance document from the U.S. Department of Labor has characterized the requirements as "set[ting] forth minimum payment standards…to ensure that a plan or issuer does not pay an unreasonably low amount to an out-of-network emergency service provider who, in turn, could simply balance bill the patient." The guidance further states that the minimum payment requirements do not apply if state law prohibits balance billing or the plan is contractually responsible for payment.[48]

Effect of Changes Related to Payment for Emergency Services and Care and Nonemergency Services and Care

The bill defines "emergency services" as the services and care to treat an "emergency medical condition," as that term is defined in s. 641.47, F.S., related to HMOs. The bill defines "nonemergency services" as the services and care to treat a condition other than an "emergency medical condition," as defined in s. 395.002, F.S. The definitions of "emergency medical condition" in both sections of existing law are substantially the same.

The bill creates a new section of law that establishes requirements for PPOs and EPOs related to coverage for emergency care. The requirements mirror federal law and are similar to state law applicable to HMOs. Specifically, the bill:

- Prohibits prior authorization;
- Requires coverage whether service is provided by a participating or nonparticipating provider; and
- Requires cost-sharing to be the same whether services are provided by a participating or nonparticipating provider.

The bill sets reimbursement to nonparticipating providers of both emergency and nonemergency services at:

- The billed amount;
- An amount that is reasonable reimbursement for the services and care; or
- A charge mutually agreed to by the insurer and the nonparticipating provider.

Reimbursement is net of any applicable copayment or coinsurance.

A provider may dispute payment that the provider believes is inadequate by sending the insurer a final offer of reimbursement within 60 days after receipt of payment. The insurer then has 30 days to respond, whether by accepting the amount or countering with an alternative final offer of reimbursement. If the parties still disagree, the provider may initiate binding arbitration within 30 days of the insurer's final offer. The Department of Financial Services (DFS) has responsibility to maintain the list of eligible arbitrators, who must meet specified qualifications, and to provide the parties with a list of five from which they must choose if they fail to agree on a selection from the broader list. The arbitrator receives the final reimbursement offers that have been made by each party and, in rendering his or her decision, is limited to choosing one or the other amount. The arbitrator provides the DFS a copy of the decision, which then is available for consideration in future arbitration actions on similar claims.

[46] 45 C.F.R. s. 147.138(b).
[47] For an insured plan, grandfathered health plan coverage is group or individual coverage in which an individual was enrolled on March 23, 2010, subject to conditions for maintaining grandfathered status as specified by law and rule. Grandfathered health plan coverage is tied to the individual or employer who obtained the coverage, not to the policy or contract form itself. An insurer may have both policyholders with grandfathered coverage and policyholders with non-grandfathered coverage insured under the same policy form, depending on whether the coverage was effective before or after March 23, 2010. (PPACA § 1251; 42 U.S.C. § 18011; 45 C.F.R. § 147.140).
[48] U.S. Dept. of Labor, Employee Benefits Security Administration, *FAQs About the Affordable Care Act Implementation Part I,* http://www.dol.gov/ebsa/faqs/faq-aca.html (last visited Jan. 16, 2015).

The arbitration shall consist only of a review of the final offers and any of the permitted documentation submitted by the parties. In making his or her determination, the arbitrator must consider such documentation, which supports one or more of the criteria set forth in the bill related to specified factors, including: patient characteristics; the provider's qualifications; provider charges; other reimbursement methodologies; and prior arbitration decisions. The bill specifies maximum timeframes for each of the steps in the arbitration process, which results in an action that may take not more than 215 days. The cost of the arbitration[49] is split between the parties and each party is responsible for his or her own attorney fees.

Miscellaneous Changes

Finally, the bill:

- Requires all PPOs to publish the list of their network providers, including specified demographic information, on their websites, and to update the list with reported changes monthly.
- Requires all PPO contracts to include a notice regarding the implications of using an out-of-network provider and the potential for balance billing.
- Subjects hospitals, ambulatory surgical centers, specialty hospitals, and urgent care centers and licensed health care practitioners to disciplinary action for violations of the prohibition on balance billing.
- Requires hospitals to publish information on their websites regarding the plans with which the hospital contracts; and providers of hospital-based services with which the hospital has contracted and how those providers may be contacted.

B. SECTION DIRECTORY:

Section 1: Amends s. 395.003, F.S., relating to licensure; denial, suspension, and revocation.
Section 2: Amends s. 395.301, F.S., relating to itemized patient bill; form and content prescribed by the agency; patient admission status notification.
Section 3: Amends s. 456.072, F.S., relating to grounds for discipline; penalties; enforcement.
Section 4: Creates s. 627.64194, F.S., relating to coverage requirements for services provided by nonparticipating providers.
Section 5: Amends s. 627.6471, F.S., relating to contracts for reduced rates of payment; limitations; coinsurance and deductibles.
Section 6: Provides an effective date of October 1, 2016.

II. FISCAL ANALYSIS & ECONOMIC IMPACT STATEMENT

A. FISCAL IMPACT ON STATE GOVERNMENT:

1. Revenues:

   None.

2. Expenditures:

   See Fiscal Comments.

B. FISCAL IMPACT ON LOCAL GOVERNMENTS:

1. Revenues:

   None.

2. Expenditures:

[49] According to research conducted by the Office of the Insurance Consumer Advocate, the estimated cost for an arbitration ranges from a low of $325 to a high of $1,500. Emails from Jennifer Ferris, Chief Counsel, Florida Department of Financial Services, Office of the Insurance Consumer Advocate, RE: Arbitration cost (Jan. 20 & 22, 2016) (on file with the House Insurance & Banking Subcommittee).

None.

C. DIRECT ECONOMIC IMPACT ON PRIVATE SECTOR:

Health care providers may experience a negative fiscal impact from the provisions that prohibit balance billing if these providers currently rely on that practice and do not receive comparable reimbursement as a result of payment received under the standard for reimbursement and arbitration procedure provided in the bill.

The bill will have a positive fiscal impact on consumers due to the prohibition on balance billing. The magnitude of the impact, however, is not known because no data currently exist to quantify the amount collected as a result of the practice.

D. FISCAL COMMENTS:

The Department of Management Services indicates that there is no impact to state group health plan members.[50] There is an indeterminate but likely insignificant negative fiscal impact on the Department of Financial Services associated with administration of the arbitration requirement.

The bill currently includes emergency transportation and ambulance services "to the extent permitted by applicable state and federal law" within the definition of "emergency services." The scope of "emergency transportation and ambulance services" is not clear, as these terms are not specifically defined in Florida statutes; however, they may contemplate covering ground ambulance services, which currently are provided in many communities by city or county government. If a local government currently relies on balance billing to fund an ambulance program, then the bill could cause the local government to suspend the program; impose a general tax increase to fund services; or impose higher user fees that may be paid, if they are collected, from individuals without health insurance (including Medicaid and Medicare).

[50] February 4, 2016, Email from Department of Management Services staff on file with the Appropriations Committee.

III. COMMENTS

A. CONSTITUTIONAL ISSUES:

1. Applicability of Municipality/County Mandates Provision:

   The bill does not appear to require counties or municipalities to take an action requiring the expenditure of funds; reduce the authority that counties or municipalities have to raise revenue in the aggregate; or reduce the percentage of state tax shared with counties or municipalities.

2. Other:

   The Supremacy Clause of the U.S. Constitution preempts state laws that impermissibly interfere with federal law. Preemption can be express or implied. When Congress chooses to expressly preempt state law, the only question for courts becomes determining whether the challenged state law is one that the federal law is intended to preempt. Implied preemption occurs either as a result of field preemption or conflict preemption. Federal law "occupies the field" when there is "no room" left for state regulation. Conflict preemption occurs where "compliance with both federal and state regulations is a physical impossibility."

   The Airline Deregulation Act of 1978 was enacted by Congress to encourage, develop, and attain an air transportation system which relies on competitive market forces to determine the quality, variety, and price of air services, among other purposes. By its terms, the act preempts the authority of a state "to enact or enforce a law, regulation, or other provision having the force and effect of law related to a price, route, or service of an air carrier that may provide air transportation under this subpart." The bill prohibits nonparticipating providers from balance billing a patient for emergency services. "Emergency services" is defined to include emergency transportation and ambulance services, "to the extent permitted by applicable state and federal law." The bill further establishes a payment methodology to be used in determining the amount of payment for covered services provided by noncontract providers. This does not itself establish a payment rate, but relates to rate setting. The language in the bill is unclear regarding its intended scope, i.e., whether it is intended to include air ambulance services or whether the phrase "to the extent permitted by applicable state and federal law" is intended to acknowledge federal preemption under the Airline Deregulation Act of 1978. If not, the application of the bill to air ambulance providers may be preempted by federal law.

3. RULE-MAKING AUTHORITY:

   None.

4. DRAFTING ISSUES OR OTHER COMMENTS:

   None.

IV. AMENDMENTS/ COMMITTEE SUBSTITUTE CHANGES

On January 19, 2016, the Insurance & Banking Subcommittee adopted a strike-all amendment and reported the bill favorably as a committee substitute. The strike-all:

- Removed the provisions in the bill that revise the methodology in current law used by HMOs to reimburse nonparticipating providers of emergency services and care.
- Added definitions of "emergency services," "nonemergency services," "facility," and "nonparticipating provider."
- Changed the methodology for determining reimbursement to nonparticipating providers of emergency and nonemergency services to:
  - The billed amount;
  - An amount that is reasonable reimbursement for the services and care; or
  - A charge mutually agreed to by the insurer and the nonparticipating providers.

- Prohibits balance billing for nonemergency services that are provided by a nonparticipating provider in a network facility where the patient had no ability and opportunity to choose a participating provider.
- Authorized nonparticipating providers of emergency and nonemergency services to initiate arbitration to determine additional reimbursement. In rendering his or her decision, the arbitrator must consider any documentation submitted by either the insurer or the provider relevant to: specified factors about the patient; the provider's qualifications; other reimbursement methodologies; and prior arbitration decisions.
- Provided that the arbitrator's decision is the amount contained in the final settlement offer from either the provider or the insurer.
- Required the DFS to develop and maintain the list of qualified arbitrators.
- Required all PPOs to publish the list of network providers, including specified demographic information, on their websites, and to update the list with reported changes monthly.
- Required all PPO contracts to include a notice regarding the implications of using an out-of-network provider and the potential for balance billing.
- Subjected certain facilities and providers subject to disciplinary action for violations of the prohibition on balance billing.
- Required hospitals to publish information on their websites regarding the plans with which the hospital contracts; and providers of hospital-based services with which the hospital has contracted and how those providers may be contacted.

This analysis is drafted to the committee substitute as passed by the Insurance & Banking Subcommittee.